

file

Form W-4  
(Rev. January 1983)

Department of the Treasury—Internal Revenue Service

OMB No. 1545-0910  
Expires 8-31-85

## Employee's Withholding Allowance Certificate

1 Type or print your full name

Menona D. Landrum

Home address (number and street or rural route)

5804 N.E. 90th Ave.,

City or town, State, and ZIP code

Vancouver, Wa. 98662

2 Your social security number

4 Total number of allowances you are claiming (from line F of the worksheet on page 2)

0

5 Additional amount, if any, you want deducted from each pay

0

6 I claim exemption from withholding because (see instructions and check boxes below that apply):

a  Last year I did not owe any Federal income tax and had a right to a full refund of ALL income tax withheld, ANDb  This year I do not expect to owe any Federal income tax and expect to have a right to a full refund of

Year

ALL income tax withheld. If both a and b apply, enter the year effective and "EXEMPT" here

c If you entered "EXEMPT" on line 6b, are you a full-time student?  Yes  No

Under the penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's signature *Menona D. Landrum* Date *March 6, 1984*

7 Employer's name and address (Employer: Complete 7, 8, and 9 only if sending to IRS)

clark county auditor, 1200 Franklin Vancouver, Wa., 98660

8 Office code

9 Employer identification number

91-6001299

EMPLOYEE UPDATE FORM EFFECTIVE FOR DECEMBER 1990  
 PLEASE REVIEW INFORMATION BELOW AND MAKE ANY ADJUSTMENT OR  
 CORRECTION REGARDING THIS AS CURRENT INFORMATION

ALL FORMS ARE TO BE RETURNED TO PAYROLL BY DECEMBER 15, 1990  
 SPECIAL ATTENTION TO AREAS OF CIVIL RESPONSIBILITY,  
 SPOUSE AND EMERGENCY CONTACT NEED TO BE UPDATED

EMPLOYEE NAME: **LANDRUM, MENONA D.** SOCIAL SECURITY#: **[REDACTED]** SPOUSE'S NAME: **LANDRUM, JOE E.**

DEPARTMENT NAME: **SHERIFF** EMERGENCY CONTACT: **JOE LANDRUM** 892-4830  
**xxx699xxx88xx**

EMPLOYEE ADDRESS **5804 NE 90TH AVE.** CITY **VANCOUVER** STATE **WA** ZIP **98661** PHONE **892-4830**

MAR	NO OF STAT	DEP	SEX	BIRTHDATE MM/DD/YY	HIREDATE MM/DD/YY	ANNIVER. DATE	CURRENT P.I.D.	STATUS
M	Sk	0	F	05/28/28	04/01/71	04/71	07/90	REG

JOB TITLE: **GENERAL-LEADWORKER A**

JOB CLASS	PSN	BUDGET#	GRADE	STEP	SALARY	HOURLY RATE	INCENTIVE
0952	3022	8028	18C	06	1974.00	11.388	99

DEDUCTION CODES: **BL02** CIVIL RESPONSIBILITY:

**WDS** RESERVE STATUS:  
 BRANCH OF SERVICE:

PREVIOUS MILITARY EXPERIENCE  
 BRANCH: **[REDACTED]** DISCHARGE DATE:

RETIREMENT SYSTEM: **LEOFF1**

SIGNATURE: *Menona D. Landrum*

AUGUST 15, 1988

EMPLOYEE  
INFORMATION UPDATE  
QUESTIONNAIRE

I AM UPDATING ALL EMPLOYEE DATA FOR THE NEW PAYROLL COMPUTER SYSTEM. PLEASE LOOK OVER THE INFORMATION LISTED AND IF ANY CHANGES NEED TO BE MADE, INDICATE THE CORRECT INFORMATION IN RED INK. PLEASE FILL IN SOMEONE TO CONTACT IN CASE OF EMERGENCY. SIGN AT BOTTOM AND RETURN TO ME. THANK YOU FOR YOUR COOPERATION. CLAUDIA

PIN: 5028

NAME: LANDRUM, MENONA, D.

ADDRESS: 5804 NE 90TH AVE.

VANCOUVER, WA 98661

PHONE: 892-4830

SOCIAL SECURITY#: [REDACTED]

BIRTHDATE: 05/28/28

EMERGENCY CONTACT: Joe E Landrum

PHONE NUMBER: 699-3000

RELATIONSHIP: Husband

\*UNDER GENERAL ORDER #12800.00 OF THE PERSONNEL REGULATIONS, IT STATES THAT ALL EMPLOYEES MUST INFORM THE PERSONNEL/PAYROLL CLERK OF ANY CHANGE IN ADDRESS OR PHONE NUMBER WITHIN 24 HOURS. THIS REQUIREMENT APPLIES EVEN WHEN A CHANGE IS OF A TEMPORARY NATURE.

Menona d Landrum  
SIGNATURE

NOTICE OF INTENT TO PARTICIPATE IN INCENTIVE PROGRAM

In accordance with Article XIII, Section III, Paragraph A, of our current labor agreement, I hereby declare my intent to participate in the Incentive Program beginning January 1, 1989 for the calendar year. I anticipate completing the basic requirements and submitting all the required documents in accordance with the following schedule:

## 1. WORK EXPERIENCE

(A) 19 years of service were completed on April 1, 1990. Documentation will be submitted by Menona D. Landrum.

(B)        years of service will be completed on       . Documentation will be submitted by       .

## 2. TRAINING &amp; EDUCATION

(A) Requirements were completed on       . Documentation will be submitted by       .

(B) Requirements will be completed on       . Documentation will be submitted by       .

## 3. PERFORMANCE RATING

(A) Cumulative average is 3 or better for year       . Documentation will be submitted by       .

## 4. FITNESS TEST

(A) Requirements were met on       . Documentation will be submitted by       .

Completion of the above requirements will qualify me for Level II (I or II) of the Incentive Program.

I understand that it is my responsibility to complete the requirements and submit the supporting documents on the appropriate forms at least thirty (30) days before participation is scheduled to begin.

DATE: February 14, 1990SIGNATURE: Menona D. Landrum

Please check off the forms you will need in order to complete your application:

- Notice of Intent to Participate
- Application for Advance Activity Approval
- Fitness Test Report
- Proposed Alternate Health Program
- Personal History Update
- Application for Incentive Pay
- Application for: Prior Training Credit
- Application for: Prior Work Experience Credit
- Application for: Prior Education Credit

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NOTICE OF ~~INTENT TO~~ PARTICIPATE IN INCENTIVE PROGRAM  
SHERIFF'S DEPT.

In accordance with Article ~~XVII~~ <sup>18</sup>, Section III, Paragraph A, of our current labor agreement, I hereby declare my intent to participate in the Incentive Program beginning January <sup>1988</sup> for the 1989 calendar year. I anticipate completing the basic requirements and submitting all the required documents in accordance with the following schedule:

1. WORK EXPERIENCE

(A) 17 years of service were completed on April 1, 1988.  
Documentation will be submitted by June 1, 1988.

(B)        years of service will be completed on       .  
Documentation will be submitted by       .

2. TRAINING & EDUCATION

(A) Requirements were completed on June 1, 1988.  
Documentation will be submitted by June 1, 1988.

(B) Requirements will be completed on       .  
Documentation will be submitted by       .

3. PERFORMANCE RATING

(A) Cumulative average is 3 or better for year       .  
Documentation will be submitted by June 1, 1988.

4. FITNESS TEST

(A) Requirements were met on       .  
Documentation will be submitted by       .

Completion of the above requirements will qualify me for Level II (I or II) of the Incentive Program.

I understand that it is my responsibility to complete the requirements and submit the supporting documents on the appropriate forms at least thirty (30) days before participation is scheduled to begin.

DATE: February 1, 1988

SIGNATURE: Mixon D. Sanderson

Please check off the forms you will need in order to complete your application:

Notice of Intent to Participate  
 Application for Advance Activity Approval  
 Fitness Test Report  
 Proposed Alternate Health Program  
 Personal History Update  
 Application for Incentive Pay  
 Application for: Prior Training Credit  
 Application for: OGGO/1dr Work Experience Credit  
 Application for: Prior Education Credit

**APPLICATION FOR MEDICAL BENEFITS**  
**NOT INCLUDED UNDER ANY INSURANCE COVERAGE**



Clark County  
**DISABILITY BOARD**  
 Room 109  
 1200 Franklin St.  
 P.O. Box 5000  
 Vancouver, WA 98668  
 (206) 699-2456

The undersigned employee of CLARK COUNTY SHERIFF's OFFICE hereby makes application to the Disability Board of Clark County, Washington for payment of medical services provided the applicant which are not payable under any other coverage available and are covered by Washington Laws, 1969, First Extra Session, Chapter 209, Section 15.

NAME OF APPLICANT: Menona D. Landrum AGE:59

ADDRESS: 5804 N.E. 90th Ave., Vancouver, Wa. 98662

History of injury or disease for which the application is filed (Attach health care professional's diagnosis and prognosis):

1) status postop interbody fusion L4-L5 for degenerated nucleus pulposus;  
 2) post op, (A)  
 Rx: quadrax

Date of treatment: 10-10-87

Total cost of treatment: \$185.00

Amount paid from insurance, pension or other sources:  
 (Attach documentation) Hill and Blue Cross process claim attach

Amount not covered from other insurance, pension, and so forth: \$85.00

ATTACH ALL BILLS FOR TREATMENT RELATIVE TO THIS CLAIM. These must be itemized showing the treatment provided ("Balance Forward" bills are unacceptable) and, when applicable, the type of drug prescribed.

I have health care insurance with:

<u>Kaiser Permanente</u>	<u>Group No.</u>
<u>xxxx Blue Cross</u>	<u>Group No. 2028</u>
<u>Washington Physicians Service</u>	<u>Group No.</u>
<u>Clark County Physicians Service</u>	<u>Group No.</u>
<u>Portland Metro Health</u>	<u>Group No.</u>
<u>Medicare</u>	<u>Plan A</u> <u>Plan B</u>
<u>Other: Blue Cross of Or</u>	<u>Group No. 47087</u>

(family member under Joe E. Landrum  
 my husband)

Menona D Landrum  
 Signature of Applicant Date 11-16-87